State of Connecticut
Office of Health Care Access
CON Determination Form
Form 2020

All persons who are requesting a determination from OHCA as to whether a CON is required for their proposed project must complete this Form 2020. The completed form should be submitted to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. PETITIONER INFORMATION

If this proposal has more than two Petitioners, please attach a separate sheet, supplying the same information for each Petitioner in the format presented in the following table.

	Petitioner	Petitioner
Full Legal Name		
Doing Business As		
Name of Parent Corporation		
Petitioner's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail		
What is the Petitioner's Status: P for profit and NP for Nonprofit		
Contact Person, including Title/Position: This Individual will be the Petitioner's Designee to receive all correspondence in this matter.		
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail		

Contact Person's Telephone Number		
Contact Person's Fax Number		
Contact Person's e-mail Address		

SECTION II. GENERAL PROPOSAL INFORMATION

a. Proposal/Project Title: _____

b. Location of proposal, identifying Street Address, Town and Zip Code:
_____

c. List each town this project is intended to serve:
_____

d. Estimated starting date for the project: _____

e. Type of Entity: (Please check *E* for Existing and *P* for Proposed in the boxes that apply)

E P		E P		E P	
☐☐	Acute Care Hospital	☐☐	Imaging Center	☐☐	Cancer Center
☐☐	Behavioral Health Provider	☐☐	Ambulatory Surgery Center	☐☐	Primary Care Clinic
☐☐	Hospital Affiliate	☐☐	Other (specify):_____		

SECTION III. EXPENDITURE INFORMATION

a. Estimated Total Project Cost: $_____

b. Please provide the following breakdown as appropriate: (may not represent the aggregate shown above)

Medical Equipment Purchases	
Major Medical Equipment Purchases	
Non-Medical Equipment Purchases*	
Land/Building/Asset Purchases	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	
Medical Equipment - Fair Market Value of Leases	
Major Medical Equipment - Fair Market Value of Leases	
Non-Medical Equipment - Fair Market Value of Leases*	
Fair Market Value of Space –Capital Leases Only	
Total Capital Cost	
Total Project Cost	
Capitalized Financing Costs (Informational Purpose Only)	

***** Provide an itemized list of all non-medical equipment to be purchase and leased.

Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit

Note: Provide copy of the vendor contract or quotation for the medical equipment.

c. Check each applicable financing method or funding source to be used for the proposal:

☐ Petitioner's Equity ☐ Capital Lease ☐ Conventional Loan

☐ Charitable Contributions ☐ Operating Lease ☐ CHEFA Financing

☐ Funded Depreciation ☐ Grant Funding ☐ Other (specify): _____

SECTION IV. PROPOSAL DESCRIPTION

Please provide a description of the proposed project, highlighting each of its important aspects, on at least one, but not more than two separate 8.5" X 11" sheets of paper. At a minimum each of the following elements need to be addressed, if applicable.

1. Identify the types of services currently provided. If applicable, provide a copy of each Department of Public Health license held by the Petitioner.

2. Identify the types of services that are being proposed and what DPH licensure categories will be sought, if applicable?

3. Identify the current population served and the target population to be served.

4. Identify the entity that will be providing the service(s).

5. Identify the entity that will be responsible for the billing of the service(s) relating to this proposal.

6. Identify the entity that owns/leases or will own/lease the physical space of the proposed equipment/service?

7. If there is more than one entity involved in this proposal, please provide copies of any and all existing or proposed contracts or written agreements entered between the two entities that relate to the proposal.

8. Provide a list that identifies the name of each petitioning or affiliate entity involved with this proposal.

9. Provide a copy of the chart of organization for each individual petitioning entity or affiliate and a corporate chart of organization, if applicable.

10. Provide a narrative that addresses the relationship of each petitioning or affiliate entity with the other entities involved with this proposal.

11. Who are the current payers of this service and identify any anticipated payer changes when the proposed project becomes operational?

SECTION V. AFFIDAVIT

To be completed by each Petitioner

Petitioner: _____

Project Title: _____

I, _____, _____
(Name) (Position – CEO or CFO)

of _____being duly sworn, depose and state that the
(Organization Name)

information provided in this CON Determination form is true and accurate to the best of my knowledge, and that _____ complies with the appropriate
(Facility Name)

and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____
Notary Public/Commissioner of Superior Court

My commission expires: _____